

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

24356

State File No.

FILED AUG 5 1957

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>77</u>	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEST PLAINS</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christa Hogan Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)		c. (Last)	
		none		premature		WRIGHT	
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>June 26, 1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
		none				Missouri	
13a. FATHER'S NAME <u>Winstead Langston Wright</u>		13b. MOTHER'S MAIDEN NAME <u>Stella Alice Jane Smith</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE, OR NAME <u>Winstead Wright</u>		ADDRESS <u>West Plains, Mo. Pottersville Rt.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature Infant (Immature)</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Undetermined</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>One Hour</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		776x	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>6/26/57</u> , 19 <u>57</u> , to <u>6/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 26</u> , 1957, and that death occurred at <u>4:00A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>M. L. Fowler</u>		(Degree or title) <u>MD</u>		23b. ADDRESS <u>West Plains</u>		23c. DATE SIGNED <u>7/27/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/27/57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Blue Mound Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Spring Creek Township</u>	
DATE REC'D BY LOCAL REG. <u>7-29-57</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE _____		ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

1000